Eye Care in the Long-Term Care Facility

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If you asked someone which sense they would be most afraid of losing, the overwhelming answer would be their sight. The dependence we have on our vision to achieve our normal daily activities is obvious. When we notice a difference in our vision, we are able to seek medical help. Long-term care residents are different only in that they sometimes do not or cannot communicate these differences with any consistent degree of reliability.

As a resident slowly loses his/her vision due to macular degeneration, glaucoma, or cataracts, the likelihood is that staff will attribute changes in personality and more dependence to dementia and physical frailty. These diseases are totally silent and only monitored and detected by professional examination. In a study reported in *The Gerontologist*, residents with reduced vision were more dependent on caregivers for performing daily activities such as toileting, transferring, and washing, than those with good vision. [1]

The visual needs of long-term care residents are different from those living independently. They gave up their motorcycle license years ago for a more sedentary lifestyle where most visual targets are within six feet. Visual tasks such as bingo, television, and admiring pictures of the grandchild, replace the computer monitors, stock pages, and driving. Some medical conditions are easy to recognize; vision loss is not. Special testing procedures by a trained professional in the facility can accurately address the visual needs of the resident.

The goal of long term care is to preserve or improve the quality of life for all residents. The reality is that the Minimum Data Set (MDS) care plan assessment for vision is often inaccurate and may result in the lack of appropriate vision care being triggered through resident assessment protocols (RAP). One study compared the results of the MDS vision patterns and an examination by an eye care practitioner. Vision was overstated 41% of the time by the MDS and understated 11%. The MDS never reported a visual field defect although 16.5% of the residents had field loss. [2] Diagnoses of cataracts, glaucoma, macular degeneration and diabetic retinopathy are by history alone. It is dangerous, at best, to rely solely on the family of a resident to be a good historian.

Eye care is a service that is often over looked in a long-term care setting. Medicare funds have been cut, yet thousands of dollars of specialized equipment must be purchased to perform various tests to detect vision problems. Fear of Medicare audits further

[1] Gerontologist 1994 Jun; 34 (3): 316-23.
[2] Optom Vis Sci 1995 Mar; 72, (3); 151-4.

dissuades many eye care specialists from entering the long-term care field. These factors complicate identification of those residents needing medical management of ocular health problems. Primary care doctors may be fully aware of the advancement in glaucoma medication, but without special equipment, they are unable to measure the effectiveness of the treatment.

Technology has evolved such that doctors are now able to transport highly sophisticated equipment, such as hand-held applanation tonometers for glaucoma measurement and computerized autorefrators for refractive error measurement. This equipment allows doctors to follow the standards of care for those residents unable to travel to the office. For example, the standard of care in glaucoma treatment includes applanation tonometry every three months with a dilated fundus exam and vision fields every year.

The maintenance of visual health will promote independence among residents and help control staff/resident ratios in this decreased funding environment. Many new glaucoma medications can be prescribed once per day, rather than three or four times per day. Dry eye therapy may require drops every two to three hours, but now may be replaced by plugs that block tear drainage. The visually deficient resident is more irritable and requires more care [3] and activities of daily living (ADL) dependency is significantly related to the presence of eye disorders. [4]

The deficiency in vision and ocular health care exists despite the best efforts of primary care physicians. The enthusiasm of doctors willing to provide the care, as well as the technology to simplify the process should be embraced to alleviate this problem. When providers offer services, a systematic approach to promote delivery of such services should be implemented. Residents and their families should be made aware of benefits available to the residents in need. Vision and ocular health evaluation should be an integral part of the physical upon admission. Physicians can utilize the specialty care to further assess the patients' systemic health and address the success in treatment of various medications to aid in decision making.

What can you do to help identify the resident in need of care? Look for the following:

- If the resident has two or more falls in a short period of time recommend an ocular evaluation. [5]
- Any resident that has a history of cataract, cataract extraction, macular degeneration, diabetes, or glaucoma should be fully evaluated.
- If the resident appears startled when approached from the right or left side, this may mean a loss in peripheral vision.
- Any sudden changes in ADLs may signify a loss of vision.
- Recurrent red eyes requiring periodic treatment by the attending physician.
- Disruptive behavior that is out of character for the resident.
- Rubbing of the eyes, "droopy" lid(s), ocular discomfort, vertigo, complaints of vision expressed by the resident and observable changes in social interest.
- Residents that do not have glasses and are over the age of 45 years are statistically out of the norm.

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[3] Gerontologist 1997 Oct; 37 (5); 620-8.
[4] J Am Geriatric Soc. 1992 Oct; 40 (10); 1018-20.
[5] J Am Geriatric Soc. 1998 Jan; 46 (1); 58-64.